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FORM **HHCS-3**
(3-22-2000)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS COLLECTING AGENT FOR THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

CURRENT PATIENT QUESTIONNAIRE

2000 NATIONAL HOME AND HOSPICE CARE SURVEY

NOTICE – Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; Paperwork Reduction Project (0920-0298) 1600 Clifton Road, MSD-24, Atlanta, GA 30333. Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

Section A – ADMINISTRATIVE INFORMATION

1. Field representative name	**2.** FR code	**3.** Date of interview
		Month / Day / Year

Section B – PATIENT INFORMATION

Current patient line number →

Section C – STATUS OF INTERVIEW

01 ☐ Complete
02 ☐ Partial
03 ☐ Patient included in sampling list in error – ***Explain in NOTES section.***
04 ☐ Incorrect sample line number selected
05 ☐ Refused
06 ☐ Assessment only
07 ☐ Unable to locate record – ***Explain in NOTES section.***
08 ☐ Less than 6 patients selected
09 ☐ Other noninterview – ***Explain in NOTES section.***
10 ☐ No current patients

NOTES

01 ☐ *Mark (X) this box if comments are written in this section or any other place on this questionnaire.*

Read to each new respondent.

In order to obtain national level data about the patients of hospices and home health agencies such as this one, we are collecting information about a sample of current patients. I will be asking questions about the background, health status, treatment, social contacts, and billing information for each sampled patient.

The information you provide will be held in strict confidence and will be used ONLY by persons involved in the survey and only for the purposes of the survey.

In answering these questions, it is especially important to locate the information in the patient's medical record. Do you have the medical file(s) and record(s) for the selected current patient(s)?

If not, ask the respondent to get it/them prior to beginning the interview. Fill sections A and B on the front of all the current patient forms while the respondent gets the records. If no record is available for a patient, try to obtain as much information as possible from whatever administrative records are available and/or from the respondent's memory.

1. What is this patient's sex?

01 ☐ Male
02 ☐ Female

2. What is her/his date of birth?

Current age

Month	Day	Year

OR _____ Years OR _____ Months

3a. Is she/he of Hispanic or Latino origin?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

HAND FLASHCARD 1.

b. Which of these best describes her/his race?

Mark (X) all that apply.

PROBE: **Any others?**

01 ☐ American Indian or Alaska Native
02 ☐ Asian
03 ☐ Black or African American
04 ☐ Native Hawaiian or other Pacific Islander
05 ☐ White
06 ☐ Other – *Specify*

NOTE – Hispanic is NOT a race.

07 ☐ Don't know

4. What is her/his current marital status?

Mark (X) only one box.

01 ☐ Married
02 ☐ Widowed
03 ☐ Divorced
04 ☐ Separated
05 ☐ Never married
06 ☐ Single
07 ☐ Don't know

HAND FLASHCARD 2.

5a. Where is she/he currently living?

Mark (X) only one box.

01 ☐ Private residence (house or apartment)
02 ☐ Rented room, boarding house
03 ☐ Retirement home or apartment, including elderly housing
04 ☐ Board and care, assisted living, or residential care facility
05 ☐ Nursing home, hospital, or other inpatient health facility (including mental health facility) – *SKIP to item 6 Introduction*
06 ☐ Other – *Specify*

b. Is she/he living with family members, nonfamily members, both family and nonfamily members, or alone?

01 ☐ With family members
02 ☐ With nonfamily members
03 ☐ With both family members and nonfamily members
04 ☐ Alone
05 ☐ Don't know

HAND FLASHCARD 3.

6. Who referred her/him to this agency?

Mark (X) all that apply.

PROBE: **Any other sources?**

01 ☐ Self/Family
02 ☐ Nursing home
03 ☐ Hospital
04 ☐ Physician
05 ☐ Health department
06 ☐ Social service agency
07 ☐ Home health agency
08 ☐ Hospice
09 ☐ Religious organization
10 ☐ Health maintenance organization
11 ☐ Friend/Neighbor
12 ☐ Other – *Specify* _____
13 ☐ Don't know

7. What was the date of her/his most recent admission with your agency, that is, the date on which she/he was admitted for the current episode of care?

Month		Day		Year			

00 ☐ Only an assessment was done for this patient (patient was not provided services by this agency)

8a. According to the medical record, what were the primary and other diagnoses at the time of that (admission/assessment)?

PROBE: **Any other diagnoses?**

01 ☐ No diagnosis
02 ☐ Admission diagnoses unknown

Primary: 1 _____

Others: 2 _____
3 _____
4 _____
5 _____
6 _____

*Refer to Q7. If **ONLY** an assessment was done for this patient, END THE INTERVIEW AND MARK STATUS CODE "06" IN SECTION C ON THE COVER. THEN GO TO the next current patient questionnaire.*

If the patient was admitted to the agency and provided services by the agency, CONTINUE this interview.

b. According to the medical records, what are her/his CURRENT primary and other diagnoses?

PROBE: **Any other diagnoses?**

01 ☐ No diagnosis
02 ☐ Same as 8a
03 ☐ Current diagnoses unknown

Primary: 1 _____

Others: 2 _____
3 _____
4 _____
5 _____
6 _____

c. According to the medical record, did she/he have any diagnostic or surgical procedures that were related to her/his admission to this agency?

01 ☐ Yes
1 _____
2 _____
02 ☐ No procedures

9. What type of care is she/he currently receiving from your agency? Is it home health care, home care, or hospice care?

01 ☐ Home health care or home care
02 ☐ Hospice care
02a ☐ In the home or usual place of residence
02b ☐ Inpatient

10a. Does she/he have a primary caregiver outside of this agency?

01 ☐ Yes
02 ☐ No . . . . . } *SKIP to item 11*
03 ☐ Don't know

b. Does she/he usually live with (her/his) primary caregiver?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

HAND FLASHCARD 5.

c. What is the relationship of the primary caregiver to the patient?

Mark (X) only one box.

01 ☐ Spouse
02 ☐ Parent
03 ☐ Child, including daughter- or son-in-law
04 ☐ Sister or brother, including sister- or brother-in-law
05 ☐ Other relative – *Specify*

06 ☐ Friend or neighbor
07 ☐ Paid help or staff of facility where patient resides
08 ☐ Other – *Specify*

09 ☐ Don't know

HAND FLASHCARD 6.

11. During the last 30 days/Since admission, which of these aids or special devices did she/he regularly use?

Mark (X) all that apply.

PROBE: **Any other aids?**

00 ☐ No aids used
01 ☐ Bedside commode
02 ☐ Blood glucose monitor
03 ☐ Cane, crutches
04 ☐ Dentures (full or partial)
05 ☐ Elevated/raised toilet seat
06 ☐ Enteral feeding equipment
07 ☐ Eyeglasses (including contact lenses)
08 ☐ Geri-chairs, lift chairs, other specialized chairs
09 ☐ Grab bars
10 ☐ Hearing aid
11 ☐ Hospital bed
12 ☐ IV therapy equipment
13 ☐ Mattress, special (eggcrate, foam, air, gel, etc.)
14 ☐ Orthotics, including braces
15 ☐ Overbed table

Respiratory therapy equipment
16 ☐ Oxygen (including oxygen concentrator)
17 ☐ Other respiratory therapy equipment

18 ☐ Shower chair/Bath bench
19 ☐ Transfer equipment
20 ☐ Walker
21 ☐ Wheel chair – Manually operated
22 ☐ Wheel chair – Motorized (including scooter)
23 ☐ Other – *Specify*

For items 12a–13b, refer to item 11.

12a. Does she/he have any difficulty in seeing (when wearing glasses)?

01 ☐ Yes
02 ☐ No
03 ☐ Not applicable (e.g., comatose)
04 ☐ Don't know

SKIP to item 13a

HAND FLASHCARD 7.

b. Is her/his sight (when wearing glasses) partially, severely, or completely impaired as defined on this card?

01 ☐ Partially impaired
02 ☐ Severely impaired
03 ☐ Completely lost, blind
04 ☐ Don't know

13a. Does she/he have any difficulty in hearing (when wearing a hearing aid)?

01 ☐ Yes
02 ☐ No
03 ☐ Not applicable (e.g., comatose)
04 ☐ Don't know

SKIP to item 14a

HAND FLASHCARD 8.

b. Is her/his hearing (when wearing a hearing aid) partially, severely, or completely impaired, as defined on this card?

01 ☐ Partially impaired
02 ☐ Severely impaired
03 ☐ Completely lost, deaf
04 ☐ Don't know

14a. Does she/he have an indwelling urinary catheter or urostomy?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

SKIP to item 15

b. Does she/he receive assistance from your agency staff in caring for this device?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

SKIP to item 16a

15. Does she/he currently have any difficulty in controlling (his/her) bladder?

01 ☐ Yes
02 ☐ No
03 ☐ Infant
04 ☐ Don't know

16a. Does she/he have a colostomy or ileostomy?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

SKIP to item 17

b. Does she/he receive assistance from your agency staff in caring for this device?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

SKIP to item 18

17. Does she/he currently have any difficulty in controlling (his/her) bowels?

01 ☐ Yes
02 ☐ No
03 ☐ Infant
04 ☐ Don't know

NOTES

	Yes	No	Don't know	Not applicable (e.g., patient is bedfast)
HAND FLASHCARD 9. **18. During the last 30 days/Since admission, did she/he receive personal help from this agency in any of the following activities as defined on this card - -** *Mark (X) one box for each activity.*				
a. **Bathing or showering?**	01 ☐	02 ☐	03 ☐	04 ☐
b. **Dressing?**	01 ☐	02 ☐	03 ☐	04 ☐
c. **Eating?**	01 ☐	02 ☐	03 ☐	04 ☐
d. **Transferring in or out of beds or chairs?**	01 ☐	02 ☐	03 ☐	04 ☐
e. **Walking?**	01 ☐	02 ☐	03 ☐	04 ☐
f. **Using the toilet room?**	01 ☐	02 ☐	03 ☐	04 ☐

	Yes	No	Don't know	Not applicable (e.g., patient is bedfast)
HAND FLASHCARD 10. **19. During the last 30 days/Since admission, did she/he receive personal help from your agency in any of the following activities as defined on this card –** *Mark (X) one box for each activity.*				
a. **Doing light housework?**	01 ☐	02 ☐	03 ☐	04 ☐
b. **Managing money?**	01 ☐	02 ☐	03 ☐	04 ☐
c. ***Shopping for groceries or clothes?***	01 ☐	02 ☐	03 ☐	04 ☐
d. **Using the telephone (dialing or receiving calls)?**	01 ☐	02 ☐	03 ☐	04 ☐
e. **Preparing meals?**	01 ☐	02 ☐	03 ☐	04 ☐
f. **Taking medications?**	01 ☐	02 ☐	03 ☐	04 ☐

HAND FLASHCARD 11.

20a. Which of these services did she/he receive FROM YOUR AGENCY during the last 30 days/since admission?

Mark (X) all that apply.

PROBE: **Any other services?**

00 ☐ None
01 ☐ Companion services
02 ☐ Continuous home care
03 ☐ Counseling
04 ☐ Dental treatment services
05 ☐ Dietary/nutritional services
06 ☐ Durable medical equipment and supplies
07 ☐ Enterostomal therapy
08 ☐ Homemaker-household services
09 ☐ IV therapy
10 ☐ Meals on Wheels
11 ☐ Medications
12 ☐ Occupational therapy
13 ☐ Pastoral care
14 ☐ Personal care
15 ☐ Physical therapy
16 ☐ Physician services
17 ☐ Psychological services
18 ☐ Referral services
19 ☐ Respiratory therapy
20 ☐ Respite care
21 ☐ Skilled nursing services
22 ☐ Social services
23 ☐ Speech therapy/Audiology
24 ☐ Spiritual care
25 ☐ Transportation
26 ☐ Vocational therapy
27 ☐ Volunteer services
28 ☐ Other high tech care (e.g., enteral nutrition, dialysis)
29 ☐ Other services – *Specify*

HAND FLASHCARD 12.

20b. Which of these service providers FROM YOUR AGENCY visited her/him during the last 30 days/since admission?

Mark (X) all that apply.

PROBE: **Any other providers?**

00 ☐ None
01 ☐ Chaplain
02 ☐ Dietitians/Nutritionists
03 ☐ Home health aides
04 ☐ Homemakers/Personal caretakers
05 ☐ Licensed practical or vocational nurses
06 ☐ Mental health specialists
07 ☐ Nursing aides and attendants
08 ☐ Occupational therapists
09 ☐ Physical therapists
10 ☐ Physicians
11 ☐ Registered nurses
12 ☐ Respiratory therapists
13 ☐ Social workers
14 ☐ Speech pathologists/Audiologists
15 ☐ Volunteers
16 ☐ Other providers – *Specify* ⇲

_____

HAND FLASHCARD 13.

21. What is the PRIMARY expected source of payment for her/his care?

Mark (X) only one source.

For the source of payment ask:
Is the *(source of payment)* for home health care or hospice care?

	Home Health Care	Hospice Care
01 ☐ Medicare	01 ☐	01 ☐
a. Fee-for-service Medicare	01a ☐	01a ☐
b. Medicare HMO	01b ☐	01b ☐
02 ☐ Medicaid	02 ☐	02 ☐
a. Fee-for-service or traditional Medicaid	02a ☐	02a ☐
b. Privately insured through Medicaid	02b ☐	02b ☐
03 ☐ Other government medical assistance	03 ☐	03 ☐
04 ☐ Private insurance	04 ☐	04 ☐
a. HMO or IPA	04a ☐	04a ☐
b. Indemnity plan or PPO	04b ☐	04b ☐
c. Other – *Specify* ⇲ _____	04c ☐	04c ☐
05 ☐ Own income, family support, Social Security benefits, retirement funds, or welfare	05 ☐	05 ☐
06 ☐ Supplemental Security Income (SSI)	06 ☐	06 ☐
07 ☐ Religious organizations, foundations, agencies	07 ☐	07 ☐
08 ☐ Veterans Administration	08 ☐	08 ☐
09 ☐ CHAMPVA/CHAMPUS	09 ☐	09 ☐
10 ☐ Other military medicine	10 ☐	10 ☐
11 ☐ Other – *Specify* ⇲ _____	11 ☐	11 ☐
12 ☐ Payment source not yet determined	*SKIP to item 24*	
13 ☐ No charge made for care	*SKIP to item 25*	

HAND FLASHCARD 13.

22. What are ALL the secondary sources of payment for her/his care?

Mark (X) all that apply.

PROBE: **Any other sources of payment?**

For the source of payment ask:
Is the *(source of payment)* **for home health care or hospice care?**

	Home Health Care	Hospice Care
00 ☐ No secondary sources		
01 ☐ Medicare	01 ☐	01 ☐
a. Fee-for-service Medicare	01a ☐	01a ☐
b. Medicare HMO	01b ☐	01b ☐
02 ☐ Medicaid	02 ☐	02 ☐
a. Fee-for-service or traditional Medicaid	02a ☐	02a ☐
b. Privately insured through Medicaid	02b ☐	02b ☐
03 ☐ Other government medical assistance	03 ☐	03 ☐
04 ☐ Private insurance	04 ☐	04 ☐
a. HMO or IPA	04a ☐	04a ☐
b. Indemnity plan or PPO	04b ☐	04b ☐
c. Other – *Specify* _____	04c ☐	04c ☐
05 ☐ Own income, family support, Social Security benefits, retirement funds, or welfare	05 ☐	05 ☐
06 ☐ Supplemental Security Income (SSI)	06 ☐	06 ☐
07 ☐ Religious organizations, foundations, agencies	07 ☐	07 ☐
08 ☐ Veterans Administration	08 ☐	08 ☐
09 ☐ CHAMPVA/CHAMPUS	09 ☐	09 ☐
10 ☐ Other military medicine	10 ☐	10 ☐
11 ☐ Other – *Specify* _____	11 ☐	11 ☐

23a. What was the last amount billed for her/his care, including all charges for services, drugs, special medical supplies, etc., before discounts or adjustments?

Total amount

$ _____ .00

01 ☐ Don't know
02 ☐ Not billed yet
} *SKIP to item 24*

b. What dates are covered by the amount billed?

Month	Day	Year		Month	Day	Year
			to			

24. Which best describes the way this agency (will be/was) reimbursed for the total charges?

01 ☐ Based on services provided
02 ☐ Capitation (services provided under a capitation agreement or by salaried staff in an HMO)
03 ☐ Don't know

25. When was the last time service was provided to this patient?

Month	Day	Year

FR Date Check – *Prior to leaving the agency, you must verify the dates you entered in other sections of this questionnaire. Copy the dates below to the space provided. Check that the dates go from the oldest to the newest and are logical. Correct errors by referring to the patient records and/or agency staff.*

	Month	Day	Year
Date of Birth – Question 2 on page 2			
Date of Admission – Question 7 on page 3			
Date last time service provided – Question 25 on page 8			
Date of Interview – Item A3 on cover			

NOTES

FILL SECTION C ON THE COVER OF THIS FORM AND CONTINUE WITH THE NEXT CURRENT PATIENT QUESTIONNAIRE.